

State of Montana
Developmental Disabilities Program
APPLICATION FOR FEDERAL TITLE XX SOCIAL SERVICES BLOCK GRANT FUNDING

Name: _____ Date of Application: _____ DDP Services Begin Date: _____

Date of Birth: _____ Date of Review: _____
Must be 18 years or older to apply

County of Residence: _____ Reviewer Names: _____

MONA Allocation: _____

Current non-Medicaid Cost Plan: _____ Request: ☐ Approved ☐ Denied

Authorizing Signature

Date

- A. Does the participant meet eligibility as determined by the Developmental Disability Program and Level of Care as referenced in the Waiver 3 form? ☐ Yes ☐ No
- B. Is the participant ineligible for Medicaid based on a trust fund and due to the terms of the trust, the trust cannot be modified such that the participant can become Medicaid eligible? ☐ Yes ☐ No
- C. Did the participant make all attempts to meet Medicaid eligibility guidelines including, but not limited to, reducing available resources to meet the Medicaid resource eligibility requirements? ☐ Yes ☐ No
- D. Does obtaining Medicaid, which would require paying an incurrment, cause a financial hardship to the participant? (If yes, the Hardship Report must be included with application) ☐ Yes ☐ No

* If the answers to questions A or C are marked **NO**, STOP HERE. Priority score is zero, otherwise complete questions 1, 2, and 3 below.

1. Does placement in this service maintain the safety of the participants due to medical issues, lack of supervision, aggression by the participant or alleged abuse by caregivers or others

- 0 --no safety issues noted Score here
- 1 --minor safety issues, not life threatening, may be issues of vulnerability in the absence of general supervision
- 2 --safety is at risk due to participant decision making, alleged abuse or neglect by caregivers, lack of supervision in current environment
- 3 --documented police, APS, or CPS involvement and there are no other services or supports available to provide protection to the participant

Comments:

2. Does placement impact the participant's ability to maintain community living or would referral to a more restrictive setting be imminent?

- 0 --placement would not impact ability to maintain community inclusion Score here
- 1 --placement would assist the participant in maintaining community inclusion
- 2 --the participant needs assistance in order to maintain community inclusion
- 3 --the participant requires ongoing supports in order to maintain independence, without service they could not maintain community inclusion

Comments:

3. Has this participant received temporary funding to deal with a current or systemic issue that would be resolved with permanent funding?

- 0 --no crisis funds being used or requested Score here
- 1 --currently receiving crisis funds

Comments:

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Hardship Report:

Instructions:

This report needs to be filled out for all participants that have an acceptance letter for Medicaid coverage but must meet the incurrment to buy the Medicaid card and are requesting Title XX funds.

Case managers need to confirm those expenses that can be easily verified such as utility bills, rent payments, etc.

In the Average Income Section:

Wages should be **NET**, not gross. Include all sources of earned income (wages) and unearned income (SSI, SSDI, trust payments, retirement payments, investment interest, etc.)

In the Average Annual Expenses Section:

- Enter the average annual expenses for each of the categories that the participant incurs costs
- Maximum allowable rent is the fair market rent for the participant's county of residence as published by the U.S. Department of Housing and Urban Development.
- In the Health and Medical Category, do not include any projected incurrment in this box. Enter just the average out-of-pocket cost for non over-the-counter medical costs
- Enter all over the counter medications in the "Food and Living Expenses" line
- For the miscellaneous category you do not need to list the type of expense. Every participant is assigned \$720.00 annually.

Client AWACS Number _____

Cost Plan Amount \$ _____

Case Manager Name _____

Case Manager Phone Number _____

Average Annual Income:

Net Wages per year	\$ _____
Unearned Income per year	\$ _____
Total Income	\$ _____

Average Annual Expenses:

Housing Expenses (Rent, Mortgage)	\$ _____
<i>Note: rent cannot exceed maximum allowable rent published by HUD</i>	
Housing Insurance (rental, homeowner)	\$ _____
Utilities (electricity, gas, water, telephone)	\$ _____
Health and Medical (NOT OTC medications or estimated incurrment , out of pocket Rx or doctor co-pays)	\$ _____
Food & Living Expenses (toiletries, household products, grooming, OTC medications)	\$ _____
Vehicle (car payments, fuel, taxes, insurance)	\$ _____
Transportation (bus pass, cab fares, etc.)	\$ _____
Debt Payments (credit cards, loans, fines, etc.)	\$ _____
Education (tuition, books, supplies)	\$ _____
Misc. Expenses (computer/internet, hobbies, subscriptions, spending money, entertainment, etc.)	\$ <u>720.00</u>
Total Expenses	\$ _____
Incurrment	\$ _____
Net Surplus/Shortage	\$ _____

June 9, 2011